THE JOURNAL OF SCHOOL HEALTH

Vo. IX JUNE, 1939 No. 6

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Published by

THE AMERICAN SCHOOL HEALTH ASSOCIATION
3335 Main St., Buffalo, New York

Editorial Office, 3335 Main St., Buffalo, New York

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Vol. IX JUNE, 1939 No. 6

EDUCATION VALUES OF SCHOOL NURSING*

MARIE SWANSON

New York State Supervisor of School Nursing

Several fundamental educational values of school nursing which underlie the general services of the nurse are so evident and have been accepted so long it is unnecessary to do more than enumerate them. Among them are:

Children's defects are more apt to get treated if there is nursing service; and children whose defects have had proper treatment are more amenable to education.

Doctors in their school examinations and teachers in their classroom observations are more accurate and persistent in discovering deviations from the normal when they know there is a school nurse available to try to see that something is done about such deviations.

Parents learn to be less careless about sending children to school with possible communicable conditions if they know a nurse is quite likely to check up if they do.

Among the most direct of the educational values of school nursing is the nurse's teaching of home hygiene, care of the sick, child care, and first aid to high school groups, adults, boy and girl scouts. Even special modified courses may be desirable to selected groups of boys and girls who will be leaving school at the earliest legal age, and who in their own family groups or employment will use the practical information and skills such a course can give them.

Another obvious fact is that there are extreme variations in the degree of educational value in the nursing work done in a school, depending upon the differing abilities of the nurses supplying the service and upon variations in the situations. Some of the factors influencing these variations are:

1. The nurse herself—her philosophy as to what her job is—whether it is to do just those things demanded of her—or whether she sees for herself possibilities for teaching beyond those outlined for her by others: It is tremendously influenced by her ability,

* Given at New England Health Education Institute, April 22, 1939, Cambridge, Mass.

native and cultivated, to teach and to establish good rapport with pupils, teachers, and parents.

These are particularly affected by two things—her initial preparation for school nursing and her in-service education. If her preparation has included public health nursing, social case work, such subject matter courses as nutrition, mental hygiene, the physical sciences, psychology, she is much more successful in educating others.

Her success is still further insured if her in-service education includes nursing supervision in addition to the benefit derived from the direction of her program by a superintendent, principal, and medical inspector whose philosophy regarding her work is that it should include incidental teaching in connection with her services to the pupils. For the help that adequate school nursing supervision can give her in developing ability to seize every possible opportunity to teach, can be given in no other way so effectively. It is hard to understand why though in other branches of nursing —in hospitals, visiting nursing associations, and even in health departments—the necessity for nursing supervision, in addition to medical and administrative direction is clearly recognized and supplied, in school nursing with a few notable exceptions it is not provided. The principal and superintendent are the first to recognize that their education and experience, which equips them for supervision of other members of their staffs, stops short when it comes to the methods and techniques of Health Service.

Because so many of a nurse's contacts with pupils (and with parents and teachers) are so personal and intimate, and are apt to occur when the individual concerned is upset by a problem and at a disadvantage, there is apt to be an emotional involvement. Since we know that the presence of emotion intensifies or blocks the learning process, the nurse needs superior teaching skill if she is to use successfully such situations.

2. The accuracy and extent of her scientific information about health:—All the interesting and important facts she was taught in the hospital regarding illnesses, valuable as they are, are insufficient. (Perhaps this should be first, as it is more disastrous when she is effective in putting across some misinformation than it is when she has some perfectly splendid material she can't share with anyone.)

3. The adequacy of time allowed for her work:—It takes so much more time as well as more skill to "give a child (or parent or teacher) guidance in developing his own idea of how to care for himself (or the special problem) now and in the future" than it does to tell him what to do.

4. The philosophy of health service held by her superintendent and by the other members of the school health staff:—

5. The physical set up—the space, privacy and efficiency of the health room:—

6. The recorded material available for her use:—

7. The proportion of pupils with whom she has personal contact:—If the nurse's activities are limited to cases of extreme urgency, referred to her by physician, teacher, or attendance officer, naturally her educational value to the group at large is much less than where she has a larger number of pleasant, natural contacts with the so-called normal children. Otherwise, she will lack opportunity to know what they need to be taught, as well as opportunity to teach. The school which has the nurse takes a larger rather than a smaller responsibility for attendance work profits by her teaching to a much greater extent. A very valuable thing she teaches children and their parents is how to use good judgment in deciding when it is more desirable for the child's own good or the protection of his fellow pupils to stay at home—teaching this, not instead of but in addition to, teaching the importance of regular attendance.

It is likely that a child's attitude toward personal discomfort, toward his own personal illnesses, is as important as any attitude the school has a part in forming. If he learns the habit, with the assistance of a short-sighted parent, of staying home from school for various attractive reasons—and then returning to school claiming illness as the cause of his absence (and is successful in establishing his false claim); if he learns to develop an imaginary headache, stomach ache, or sore throat, in order to be excused from school when there is some activity he does not like; if he gets an undue sense of importance from the spotlight put on him because of a trivial accident; if he learns to avoid physical education activity by a false claim of physical disability, then we are helping him get a very bad education. But, if a child with an actual claim, is told by his teacher, or by the nurse, "You have no pain, go back to work," we are giving him a bad education, for we are building in him an attitude of distrust of the powers that be and a justified resentment against authority.

But how can even the cleverest nurse look at a child and know his head does or does not ache? She can't. But, there are some very definite things she can do to make this a better educational experience for the child. She can learn to know each individual child, she can gather information about him that will help her handle most wisely each such situation as it comes up. How can she do this for a thousand or fifteen hundred children? She can't. But, she can participate in, and stimulate the gathering of such information from and by the child himself, his parents, his teachers, the attendance worker, the school physician, his family doctor, and all the rest.

The use of an ordinary manilla correspondence folder for each pupil, instead of limiting information about him to the small amount that will go on a single health record card is one step toward this. Usually the easier we make it for such material to accumulate the more apt it is to accumulate. Throughout one school year many things can be allowed to gather quite informally in this folder. At the end of the year, when perspective enables us to decide that certain things have no significance, they may be thrown away; others may be summarized, and a brief entry made on the individual health record card of the pupil; a few may be elaborated.

These materials include: notes from the parents regarding illness absences, from the family physician or clinic, carbon copies of the notes sent by the school to the parents regarding defects needing treatment or accidents that happened to him in school, or explanations when he was sent home from school for some health reason; memoranda regarding home or school interviews with parents on such subjects, memoranda (or carbons of them) sent by the teacher to the nurse with the child when he was sent to the health office for special inspection, first aid, or any other reason; the nurse's own notes on her discussion with the child, or his teacher, or of her observation of the child. These are among the most important items.

If such data are supplemented at the end of the year by summaries of the classroom teacher's observations, as they have observed the child day by day, throughout the year, the record, even for children who have shown no special problems, is built up.

Many nurses who have gone to the trouble of preparing for each classroom teacher, a list of the defects found in the health examination of her pupils and of the recommendations made, by failing to take an extra step or two have lost much potentially valuable information. By encouraging the teacher to enter on this list her own observations, the nurse is not only perpetuating information of possible value to the health record, but she is using an opportunity to function as an educator of teachers. Many schools are now in the process of endeavoring through in-service education, to develop the ability of the teachers to make and record pertinent observations of their "normal" pupils as well as of their "problem" ones for use in guidance work. As the nurse has conferences with the teacher, regarding health problems of the pupils, she suggests that the teacher put this or that on the record (she does not do it for her). When the school physician is about to examine this teacher's group, the nurse has a special conference with her, discussing her observations of each pupil, and encouraging the teacher to put down the items that may help the physician understand the child better. After the examination, the nurse returns the list to the teacher with the doctor's recommendations noted,

and explains the finding to her. The teacher keeps the list, and continues to add data. As treatment for defects is obtained, for instance, the nurse discusses it with the teacher, who by recording the facts increases her knowledge of community agencies and of facilities available.

Some schools are integrating health records and guidance records. The nurse and physician readily see how they can profit by any social, emotional, intelligence, or scholastic record of the child, but there still is a fear, in few instances justified, on the part of the nurse and doctor, of sharing their information with "lay" people.

If the nurse has at hand a folder with the information described, when a child is sent to her complaining of illness, she can at least know if he has been in the habit of complaining frequently, or if he has any known physical condition with which this might be associated. Perhaps she takes his temperature. Some nurses do:

1. When a child is ill in school.
2. In making a home call on an ill child, if a physician is not in attendance and if the mother has not taken it.
3. When a child is returning to school after an illness without a physician's statement.

Some of the educational advantages of such a procedure are:

1. It is being emphasized to the child and his parents that there is scientific objective data to be obtained in addition to subjective symptoms.
2. In the case of the child at school he has the comforting feeling that he is getting some serious consideration. Refusal of a pupil's request for aspirin, "cold tablets" or "some medicine to gargle" is not only made more pleasant but much more constructive if an alternative and better plan of action is offered.
3. The nurse is doing her part to popularize the use of the thermometer—a real contribution to the pneumonia control program.
4. She is teaching how to use it properly.

Another possible source of information, in addition to the thermometer reading and the record, is a leisurely discussion with the child, reviewing with him his health practices for the last day or two to determine lack of sleep, upset at home, irregular eating, and the like as possible causes. In cases of malingering, she is giving him real education if she leads him to tell her he was "just fooling" instead of *her* telling *him*, for she then has an opportunity to help him deal with his real problem which occasioned this false complaint.

Instead of snubbing the child who demands continual attention, she tries, with help she may get from his teachers and a study

of his home environment, to discover *why* he wants attention so that she may help him work out for himself a more desirable satisfaction.

An excellent method of helping immature individuals develop maturity is the responsibility of serving as "Nurse's Helpers", "Health room managers", "Health Committee", or whatever they wish to call themselves. The opportunity for worthwhile work, involving initiative and leadership, as well as routine daily responsibility, under carefully prepared written instructions and supervision of the nurse is a valuable method of improving morale. By having these helpers, the health room can always be open even when the nurse is not in it. This makes possible "rest periods" for post-convalescent pupils, and modified programs for others who might otherwise be obliged to miss an entire session, thus receiving practical education in adjusting activity to a physical condition.

When an epidemic occurs, the nurse has certain responsibilities. She may handle these to get good education or bad, especially with parents and teachers. Definite, scientific, and dignified special bulletins to these groups, when epidemics exist or threaten, keep these people informed of the exact state of affairs, and give careful, specific instructions as to just what they may do to help calm hysteria and build constructively for future understanding and proper management.

Probably the knowledge the nurse gains of the home is the most valuable of all the educational services she can render to the schools, and is additionally valuable in proportion to her ability to present it to the teacher in usable form.

Nurses are fortunate in the richness of the opportunities they have for teaching, only a few of which I have discussed,—ideal opportunities to contribute to the healthful living of "all the children of all the people."

* * * * *

Place to Eat Lunch,—Many students going to rural and urban schools carry lunches. However, many schools provide no place to eat these lunches, consequently we find lunches being consumed on playgrounds, stairways, in cars, and even toilet rooms. It would be much more satisfactory to all concerned if a suitable place were designated for this purpose.

A small table and chairs of suitable height will solve this problem in the small rural school; napkins spread on the desks make an individual table for each child. In the urban schools, an empty room or storage room in the basement may often be made into an attractive lunch room by the ingenuity of an interested Home Economics, Art, or Manual Training Department cooperating with the Parent-Teacher Association. If no such room is available, several class rooms might be designated to serve as lunch rooms.

Illinois Health Messenger, April 1, 1939, p. 75.

THE DELICATE CHILD

C. MORLEY SELLERY, M. D.*

The term "delicate child" has been used rather loosely for many years to designate one who is frail, subject to illness, or of inferior constitution. These so-called delicate children are in our classrooms in large numbers and constitute a challenge to the school and home to lift them out of this category.

Some parents seem to feel that the matter is adequately summed up and disposed of when they state that "Mary has always been delicate." We should vigorously resist the inclination to accept such a label on any child. While all children are not equally vigorous, undoubtedly many so-called delicate children could be restored to normal health and vigor. We must also remember that children readily accept labeling, and the delicate or nervous child, so called, is likely to learn to enjoy the pampering and privileges which he finds accrue to him as a result of his infirmity.

Understanding and treating these children will be very much facilitated by clearer thinking regarding the underlying causes. Let us take a look then at the various types of delicate children commonly found in our classrooms. There are two main groups: (1) Those who are likely to be more or less permanently delicate on account of an irremediable condition or a chronic ailment not easily cured. (2) Those who are temporarily delicate due to some physical defect, environmental maladjustment or improper health habits. In the first class may be included the cardiac, the tuberculous, and the child with an inferior constitution of hereditary origin.

While we may not be able to make strong, robust individuals out of these children so that they may later take part in the more exacting forms of competitive sports or life activities of similar intensity, it should never be forgotten that every child has an optimal physical and mental condition which he should strive both to attain and maintain. Every effort should be made to assist these children to live on the plane of what is for them maximum efficiency, so that they may enjoy life to its fullest and achieve the highest of which they are individually capable.

Let us review briefly some of the symptoms which children in these various groups are apt to present and consider protective measures which might be applied.

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* Substitute Director of Health Service, Los Angeles City School District. Reprinted from Health News, published by Los Angeles City School District, March, 1939, p. 7.

Group I

The Cardiacs,—The milder cases of heart trouble may not present any marked symptoms and are likely to be missed, hence the necessity for physical examination of all children by school physicians. Not that the family physician could not make this examination, but thousands of our children never see a family physician and other thousands who do, see him only when suffering from a severe illness. Mild cardiac disturbances or even lesions when recognized early and given proper medical care may improve to such an extent that full activities may be carried on with perfect safety. Whether these results are attained depends on early care and the amount of actual cardiac damage.

Children with more serious lesions will show: (a) Symptoms of fatigue following slight exertion, (b) breathlessness easily induced and lasting longer than normal, (c) paleness or pastiness of the skin—in serious cases the lips may be blue, (d) occasionally pain in the chest, palpitation, dizziness, or a pinched anxious expression.

Children with heart trouble are frequently nervous and apprehensive. They are easily excited. In protecting these children it is important to keep this in mind and spare them as far as possible from classroom competition. Such children should be treated with gentleness and consideration and allowed to recite first in class so as to relieve them from worry and tension. Special arrangements should be made for tardy slips when the child has to walk to school and where school buildings are far apart. In severe cases the school program should be lightened or only part-time attendance permitted. Children who would not do well in a regular school progress favorably under the modified program of a school for the handicapped. Rest periods are arranged according to the physician's instructions. Where the heart reserve is so poor that the child cannot stand even the modified program for the handicapped, a home teacher should be provided.

The Tuberculous,—Undoubtedly a certain number of children suffering from childhood-type tuberculosis might be included in the group commonly designated as delicate. It is a matter of observation that these children, while not presenting the symptoms usually associated with the adult type of tuberculosis, nevertheless have a low margin of physical reserve and on a normal-activity program develop symptoms of chronic fatigue out of proportion to the strenuousness of the exertion compared with normal children. These tuberculous children may require years of special care, with work and rest carefully adjusted to their individual capacities and requirements. That tired-looking child who rests his head on the desk so frequently may have an active childhood type of tuberculosis. It is of course much more probable that he attended a late movie, but it is our responsibility to find out what

is behind the physical disabilities of our school children.

The Child of Inferior Constitution of Hereditary Origin,— These children conform more or less closely to our preconceived notions of delicate children. Even when all discoverable physical defects have been corrected and reasonable health habits established, they still remain physically under-par children. Their tissues lack tone. The skin appears to be almost translucent with an alabaster-like whiteness. The hands are thin and bony and usually cold to the touch. Their whole appearance is one of frailness. They catch cold easily, and spend much of their time out of school on account of illness. In this group are found the children who suffer from what has been called "the sickness of school." They are unable to stand the demands of a full, busy day, of early hours, rigid punctuality, the rush of many people, noise, the changing of classes, reciting, the long day and the walk home. They arrive home exhausted, and feel pushed to the wall by the very thought of home work. School is a perpetual nightmare. They do not sleep well because they dread the coming of another day with all its responsibilities.

On account of their many illnesses and general frailness, these children are often much pampered at home. In the better-class homes they are often over-doctored. The family never quite gives up hope of finding the cause of their frailness and takes them from one doctor to another. They are x-rayed and tested and retested with no very definite findings until they become hypochondriacal and a very encyclopedia of medical information, especially as it relates to themselves. On the other hand, if they are stimulated to over-activity either physically or mentally they are likely to become the prey to recurrent illnesses. These youngsters cannot be hardened by pushing them into athletics with the idea of counteracting the pampering of the parents. Most important in the treatment of these children is a school and home program suited to their individual strength and capacities. A well-balanced diet, a rest program, as much outdoor life as possible, always stopping short of fatigue, are essentials. The health supervision should be careful but casual, so that their thoughts may be directed away from themselves. Some of these children require occasional periods of exemption from school attendance, with complete release from as much nervous tension as possible.

Group II

In the second main group are children who have been classified as temporarily delicate due to some physical defect, environmental maladjustment, or improper health habits. Unfortunately, many of these children remain in this classification for years, so that their impaired physical condition may indeed become permanent. The children in this group constitute our greatest challenge. No

stone should be left unturned to restore them to normal physical and mental vigor.

Malnutrition,—This may be largely a matter of inadequate or improper diet, or over-activity and insufficient rest in an otherwise normal child, and probably constitutes the largest problem in this group. It should always be kept in mind, however, that malnutrition may be the objective evidence of dysfunction or disease of some part of our system and always calls for a searching investigation. These children are frequently pale or pasty in color. Many have dark circles under the eyes, dry skin, dry and brittle hair, dull lusterless eyes. They may be thin or under-weight or if weight is normal or excessive, the muscles and subcutaneous tissues are flabby.

Children with foci of infection,—The delicate child may be fighting foci of infection. Abscessed or decayed teeth, diseased tonsils and adenoids, sinus, kidney, and rheumatic infections are among the commonest to leave their mark of ill health upon the child. Every physician has seen children who for years have been frail and weak—bowled over by every wind that blows—rapidly change into fine study specimens of humanity on the removal of diseased tonsils and adenoids, or the elimination of other foci of infection.

The hothouse type,—Another type in this group is the pampered, coddled, overprotected, overclothed child who was never allowed to discontinue convalescing from a serious illness of infancy or childhood. He is often an only child who has been so weakened by hothouse treatment that his frequent illnesses, mostly colds, sore throat and bronchitis, confirm the parents in the conviction that he is by nature exceedingly delicate. The child usually shares the conviction of the parents. A patient, sympathetic approach must be made to this problem, with the gradual education of the parent and child in health habits which will promote bodily vigor. Summer camp life with a group of normal boys or girls is frequently the best way to begin the rehabilitation of these children.

Post-infectious depression,—This is a term used to describe the condition of lowered bodily function and vigor which follows any serious or prolonged illness of an infectious nature, such as influenza, septic tonsillitis, whooping-cough, scarlet fever, diphtheria, etc. The more severe cases suffer from moderate anemia, and present such symptoms as pallor, irritability, poor appetite and fatigue on slight exertion. These children are not in reality delicate children, because they are potentially normal children who need temporarily to be protected from a full program. In protecting these children the first essential is adequate rest. Many of them should not be in school. The milder cases should be in rest classes with rigid restriction of extra-curricular activities.

Some of our heart cases, many of our posture cases, and much lighting up of tuberculosis in adolescent years come from these children not being recognized and given the type of physical care which they require at this critical period of their lives. In many cases the parents are at fault, permitting the child to return to school too soon and exerting little or no control over the activities and bedtime of the child in the home.

Emotionally unbalanced children,—These are often found in the group of so-called delicate children. They are usually the victims of environmental maladjustments. Because of the emotional turmoil in which they live, their whole body is in a condition of dysfunction. Their digestion is poor. They are restless and irritable and usually much underweight.

Allergic type,—Other children commonly considered in this category are the asthmatic or allergic. They react badly to physical activity and have poor muscular development. They suffer restless nights from frequent bouts of coughing. In many cases they have restricted diets, or should have, because of food allergies from which they suffer. A careful search should be made for the cause of their asthma. In the meantime rest, corrective efforts, and a modified school program depending on the severity of the asthma are the best protective measures.

Under the heading, "the delicate child," many other causal factors might be considered. The above-mentioned types of children, however, are found in our schools in large numbers. If we are to protect them and, where possible, assist them to achieve a condition of optimal health, it is obviously necessary that we should be aware of them as individuals with special health problems which call for solution. There are two essentials for discovery and guidance of these children—an alert informed body of classroom teachers and an adequate staff of school health personnel.

Clarence D. Hart, M.D., C.P.H.,—Dr. Hart, recently appointed Health Officer of Savannah and Chatham County, Georgia, died on April 10, 1939. He was born in 1895, and graduated from Albany Medical College in 1931, receiving his license in Michigan in 1936.

* * * * *

THE INCIDENCE OF VINCENT'S INFECTION IN THE SCHOOL CHILDREN OF KANSAS*

LEON R. KRAMER, D.D.S.,

Director, Division of Dental Hygiene, Kansas State Board of Health.

Findings in the various groups follow:

Group 1. This included 556 white persons, families on direct relief in Marshall County, in June 1937. In the group of 60 pre-school children, one was found to have positive clinical plus positive microscopic findings, and two were found to have strongly positive microscopic findings.

In the group of 254 school children, 13.7% had mouths with strong positive microscopic and clinical findings. In the group of 242 adults, 22% presented strong findings, both microscopically and clinically.

Less than 32% of the adults were free from strong microscopic evidence of Vincent's infection; 50% of the children of school age presented negative mouths. Findings of scattered fusiform bacilli and spirochetes were found in approximately 18% of the pre-school children examined.

Group 2. This group consisted of 502 white children, grades 7 and 8 of the Junior High School, Coffeyville. Examinations were made in December, 1937. These children were selected as a control group, since it represented a typical cross-section of the school children of an entire city of the first-class. The findings were as follows: Negative, 51.4%; mildly positive, 32.5%; positive microscopically, 17.1%; positive microscopically and clinically, 8.67%.

Group 3. This group composed of 350 colored children, grades 1 - 12, which represented a cross-section of the colored children of Coffeyville. The findings from this group follow: Negative, 57.7%; mildly positive, 18.6%; positive microscopically, 23.7%; positive microscopically and clinically, 14%.

The portable laboratory was set up with an extra microscope. The children could see the process of fixing, staining, and reading the slides, and were allowed to view the stained smears through the microscope. A remarkable interest was demonstrated. One hundred and eighty-seven children, which included the definitely positive cases, were given slips, by the school nurse, stating that the child had a disease of the gums that was communicable. These slips instructed them to go to their family dentist for treatment during the Christmas holidays and to return the slips, signed by

* Read before Section on Epidemiology of the American Public Health Association, Kansas City, Mo., Thursday, October 27, 1938. Continued from May Journal.

their dentist, showing that the disease had been treated. These slips were to be presented to the school nurse upon return to school after the holidays. Every child returned his slip, showing treatment had been rendered. This co-operation we believe is due to the positive educational value in arousing the children's interest in mouth health through the set-up of the portable laboratory. The local newspaper carried an entire column on the front page, each of the two days, describing the set-up and the findings of the bacteriological survey.

Group 4. In this group were 730 school children, grades 1-12, representing a cross-section of the country and city schools of a typical rural county. Rooks County is located a little north of the center of the state. The cities are all of the third class. Rooks County is neither highly prosperous nor is it in the lowest economic bracket. In this county, a complete physical and dental examination was made by the personnel of the divisions of child and dental hygiene of the state health department. The conference was held in February, 1938. The findings of the Vincent's survey were: Negative, 50%; mildly positive, 34.3%; positive microscopically, 15.7%; positive microscopically and clinically, 7.2%. Of the 730 children tested, there were only four cases where gum lesions were apparent, that the microscopic findings for Vincent's infection were negative.

The comparative figures on the total findings of the four groups of school children are shown on the accompanying chart (Exhibit 1).

The findings of a Survey of Vincent's Infection of the Mouths of 1,836 School Children in Kansas

Group	No. Tested	Neg.	Mild Pos.	Micro. Pos.	M. and Clin. Pos.
1. School Children—White Indigent Families Marshall County	254	50%	27.8%	22.2%	13.7%
2. Negro School Children Coffeyville, Kansas	350	57.7%	18.6%	23.7%	14%
3. White School Children Coffeyville, Kansas	502	51.4%	32.5%	17.1%	8.67%
4. School Children—White Rural—Rooks County	730	50%	34.3%	15.7%	7.2%

The above findings show the relation of the incidence of infection to the economic status of the four groups. The incidence of positive Vincent's infection is almost identical in the negro children, to that of children of indigent families. After considerable study of conditions common to both groups we found that a diet lacking in sources of vitamin C and negligence in oral hygiene were the major points in common. The negro children examined had fewer decayed teeth than did the white children, yet the incidence of infection was greater. This discovery caused us to study the association of dental disease to that of gum lesions with Vincent's infection. We found two rural schools in which the

children had little or no decay. In the first school, with eight pupils, we found two children with positive microscopic and clinical findings, two had strongly positive microscopic findings, two had mildly positive microscopic findings, and two had negative smears. In another school, having five children, with comparable dental conditions, there were negative findings in the entire school. These records, with others, lead us to believe that disease of the teeth is entirely divorced from Vincent's infection of the gums.

Another interesting group included six boys, who asked to have their tests run immediately after school, so they could practice basketball. Two had strong positive clinical and microscopic findings, two had strong microscopic findings, and two had mild microscopic findings. Yet some of our athletic directors say that their athletes are strong, healthy youngsters, and that therefore they need pay no attention to towels and drinking water facilities as health hazards.

Group 5 illustrates remarkably well the alarming amount of infection found in the freshman class in a high school in Rooks County. Seventeen per cent definitely had Vincent's infection, and 25 out of the 38 students had either strongly or mildly positive microscopic readings.

Another interesting picture was presented in the list of names showing positive microscopic and clinical findings. In looking down the list we find from two to six children to be members of the same family. Group 7 shows that fathers, mothers, married children and school children all of the same family, had positive findings. One of the chief complaints made by dentists, in the treatment of Vincent's infection, is that in many instances one may treat a mouth over a period of months and still be able to get a positive smear. These findings point to a solution of this problem. Too often, Vincent's infection is treated as the individual problem of the person having the acute disease. We invariably look for the source of infection outside of the immediate family. The family picture should alter the attack on the treatment of Vincent's infection. How can one expect a negative smear from a mouth, even after treating it over a long period of time, if every member of the family is a constant source of re-infection? The treatment of Vincent's infection must be more seriously considered as a family affair, and the plan for treatments should be outlined accordingly.

Smears were taken from 24 dentures and 18 edentulous mouths. We can corroborate the findings made by a student of Vincent's infection, in that no Vincent organisms were found. Smears taken from the mouths of eight infants were also negative.

We have purposely avoided etiological factors, other than diet and oral hygiene, that reduce the resistance of the gums, such as

the irritation from impinging restorations, the presence of hard tartar on the necks of teeth, and other factors. We have also avoided the subject of treatment and the phases of operative control for fear of distracting attention from the public health aspect of the disease, that of prevention. If a means can be devised to control this disease, especially as it affects pre-school and school children, a great step will be made in the prevention of acute, subacute, and chronic oral lesions of the gums and their sequallae of ill health.

In summarizing the findings of this survey, they will be listed in the order of the original objectives.

The first objective was to learn the incidence of Vincent's infection in the school children in Kansas. This was found to be 7.2% to 14%, varying according to the economic status. The major causitive factors appear to be dietary deficiency, especially in Vitamin C and negligence in oral hygiene.

Additional findings: Uninvolved dental caries has little or no relation to gum lesions. Vincent's organisms are present in practically all stages of gingival pathology. Vincent's organisms may be found in approximately 50% of the mouths of school children in Kansas. Treatment of all gum pathology must take into consideration the prevalance of the Vincent's organisms. The immediate family is probably the source of a large percent of Vincent's infection in school children. The apparently healthy body of a young school athlete is no index to the health of the mouth. Anyone who has natural teeth is a prospective of Vincent's infection. The prevalance of Vincent's infection in school children is a major public health problem.

The second objective was to test the possibilities of bacteriology as an educational feature. The fact that each of the 187 children having positive Vincent's findings in their mouths returned their slips showing treatment had been rendered, is evidence of its educational value among school children.

Since sufficient interest in the project was shown by the editor of the local newspaper to devote a full column on the front page in each of two days' issues, it warrants praise as related to adult education.

The third objective was to arouse student interest in oral hygiene: The school nurse reported that "Many of the school children must have made a new resolution to brush their teeth twice a day because the druggists reported a great increase in the sales of tooth brushes and pastes and many children were being excused from their classes to fill the appointments with their dentists."

Suggested solution: The solution of the problem seems to lie both in the home and in the classroom. The prevention of Vincent's infection in school children, involves their having a balanced diet

plus the education afforded by an effective oral health program. The teacher will need the assistance of the parents, the dentist, the school physician, the nurse, the dental hygienist and the nutritionist effectively to execute a program of this nature in her classroom.

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Study of School Health Program,—At a recent meeting of the County Medical Society, Westchester County, New York a resolution was passed asking the State Medical Society to appoint a special commission representative of school physicians, private physicians, and experts in health education to study the school health program in New York State and to formulate recommendations. The gist of the resolution follows:

"Whereas, there is an evident need for an immediate general reconsideration of:

1. the ecomonic factors underlying school medical service;
2. the educational qualifications of school physicians and the establishment of professional supervision of their work;
3. the professional status of the school physician in the school system and his relationship to his colleagues in the community;
4. the proper scope of the required services and the proper basis of remuneration for the school physician;
5. the desirable function of the school physician in health education."

Resolved, That the House of Delegates appoint a Commission to study—

"What changes are needed in law and in administrative practice to place the school health service upon a sound economic and professional basis, to equip the school physician for leadership in health education, to correlate the school health program with the educational program as a whole, and to correlate the school health service with the official health agencies and the medical profession in the community?"

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SCHOOL HEALTH DEMONSTRATIONS FOR TEACHERS - IN - SERVICE*

THELMA SUGGETT

Supervisor, School Health Education, Missouri State Health Department.

Few public schools in Missouri, except in large metropolitan centers, maintain the services of a school physician or nurse. Also, there are in this state 7,959 small rural schools which are without adequate professional health service chiefly because of the scarcity of physicians in the rural areas. The average age of physicians in rural Missouri is approximately 58 years. As these men retire from active service they are not being replaced to any proper extent by younger physicians, making it increasingly difficult for the schools to secure local professional service.

Even if sufficient medical and nursing personnel were available, it would remain the duty of the individual teacher to familiarize himself with the deviations from normal and be prepared to carry on a routine school program within his own realm as a teacher.

Approximately 8,500 teachers are employed by the rural school system of Missouri which enrolls about 182,000 children. These teachers represent varying degrees of teacher training and experience. How were they to be reached with a school health program that would fit their needs?

For nearly two years the State Health Department and the State Department of Education have been at work on a cooperative health program for the public schools. The Supervisor of Health Education serves as a coordinator of the two state departments. Faced with the problem of improving the health program in the rural schools, and with but one worker available from the state departments, it was clearly evident that the teachers must be reached in groups. Casting about for a method that would be more effective than an ordinary teachers' meeting, the idea of a demonstration was considered and selected because it would permit teachers to *see* how to carry on certain school health procedures rather than merely to hear them talked about.

With the cooperation of county and city superintendents of schools and the health officers in the field, demonstrations were scheduled in twenty-two counties covering virtually all sections of the state. These served to sample the state with the program, and test its effectiveness in all sections.

The demonstrations required a full day, and were conducted by the State Supervisor of Health Education with the assistance of a public health nurse provided by the State Health Department.

* In rural and small town schools.

The meetings were open to teachers in both rural and town school systems, members of boards of education in the county, representatives of Parent-Teacher Associations, local physicians, nurses, and dentists.

Eight fundamentals of the school health program were included in the demonstrations, and other problems were considered. These were: Morning inspection, vision testing, hearing testing, handwashing, hot lunch, weighing and measuring, birth registration, and first aid. Teachers in the audience had opportunity to participate in the meeting by assuming the role of elementary school children and serving as subjects for the demonstrations. Supplies for the demonstrations were purchased at a minimum cost, and carried from county to county. In each case the teachers were told where they could buy the essential supplies, and at what cost, to demonstrate to school board members, teachers, and parents that a rather adequate school health program may be carried on in the average rural or small town school with little expense to the school district. Twelve-page booklets called "Health Aids for Teachers" were prepared especially for distribution at these meetings. These contain a review of the demonstrations, together with references and other pertinent material for the teachers. Free and low cost health educational materials were displayed at the demonstrations, and teachers were given opportunity to examine them and make notes on their source in order to request later the records, pamphlets, and posters which they needed.

It is difficult to evaluate such a program as this, at least until the effects have had time to appear. However, before planning to extend these demonstrations to the 92 remaining counties in the state during the next school year, an attempt at evaluation was made by sending a brief questionnaire to county superintendents whose teachers had seen the demonstrations in the 22 counties visited. The questionnaire sought to find out whether or not the demonstrations were considered beneficial and practical. The superintendents were asked to list other phases of the school health program that might well be included in such a demonstration, and to list their criticisms and suggestions.

Following are a few of the comments received: "The teachers were well pleased and consider this one of the most practical meetings ever held." "Found much improvement in handwashing after the demonstration." "Our teachers have put into operation many of the suggestions that were made." "Handwashing and hot lunch seemed best to me." "Would like to have the demonstration early next fall for new teachers." "The demonstration held the interest of the teachers and was very practical." "The importance of teacher health might be stressed." "Suggest you stress heating and ventilation."

The 22 demonstrations conducted during the spring of this year reached 2,400 elementary teachers in rural and small town school systems. This program will be resumed early in the next school year, and made available to as many more counties as request it. Similar demonstrations adapted to city school systems will be included in the next year's plans.

From the beginning this program was designed to make up, in a way, for inadequacies in teacher training. Whenever the state teachers' colleges include methods and materials in health education in their curricula and provide well trained health educators on their staffs, this type of in-service program may perhaps be discontinued. Under present conditions, however, it is felt that by showing teachers how to inspect for communicable diseases, test vision and hearing, serve a hot luncheon, provide for handwashing and first aid, they are better able to fulfill their obligations to the children who come under their supervision.

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Undulant Fever On Increase,—The prevalence of undulant fever has followed a strong upward trend in Illinois during recent months. While the incidence is still not great, the number of cases reported last year, 212, was almost exactly twice the number, 107, reported in 1937, and higher by a wide margin than in any previous year. This upward trend has continued at an accelerated rate to date in 1939.

Undulant fever is spread to man principally from infected cattle and swine. Commonly called contagious abortion in domestic stock, the infection is known also as Bang's disease in cattle and as Traum's disease in swine. Goats may be the source of infection also. The disease is transmitted to human beings usually (1) through unpasteurized milk from infected cattle or goats, (2) by contact of people with infected cattle or swine, and (3) through the handling of carcases of infected animals.

Pasteurization is an effective way of preventing the disease that would otherwise be spread through contaminated milk. Illinois Health Messenger, April 1, 1939, p. 74.

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Tularemia,—The biggest epidemic of tularemia, commonly called rabbit fever, ever recorded in Illinois ended in February of 1939. Starting early in November, 1938, simultaneously with the opening of rabbit hunting season, the disease climbed rapidly to peak prevalence in December, and then declined sharply. During the four months, 501 cases were reported, 55 in November, 350 in December, 70 in January, and 26 in February. This was by far the highest incidence of the disease on record in Illinois for a rabbit hunting season. Illinois Health Messenger, April 15, 1939, p. 79.

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"INTELLIGENCE" QUOTIENTS*

A. CAROLINE SCHMEHL

Clinic workers are very frequently asked the question, "Why is it that this child has an Otis I. Q. of 110 and a Terman one of only 90?"

In the first place, the result derived from the Otis self-administering tests is not an intelligence quotient or I. Q. It is a score. This score, by the use of specific tables is transformable into a "mental age equivalent," an approximation of the child's real mental age. Schools often forget the words *equivalent* and *approximation* and use the transformed mental age as a real mental age. From a chronological age and a mental age, an intelligence quotient, of course, is easily computed.

This procedure, however, is fallacious. A real mental age can be determined only by the use of the Terman revision of the Binet-Simon scale. This is because it is the only scale for testing mental ability which is divided into age levels. By age levels we mean a series of tests at a given chronological age. These levels were not determined arbitrarily, *but* after careful investigation which allocated the chronological age at which the test should be placed. Other tests—the group scales, the point scales, and the various revisions of the Binet-Simon scale—were not formulated in this manner. The authors of these scales specifically state in their test directions that the results obtained from their tests are *scores* and *not mental ages.*

These group tests are very valuable for the purpose of selecting more homogeneous groups. For the most part, the correlation between those results and the results of the Terman revision of the Binet-Simon tests suggests a high positive one. However, because a thousand or more Terman mental ages show a high positive correlation with a thousand Otis scores does not mean that the variation of individual scores will be limited to a narrow range. Statistically, this assumption is also fallacious as the slight variation between the results in a majority of cases would counteract a wider variation in as many as one hundred cases out of the possible thousand.

In other words, one cannot assume with a reasonable degree of logic and success that a high Otis score presupposes an equally high Terman mental age. It may be true and very often is so. But one does not necessarily follow from the other, any more than a grade of 90 in sewing follows logically or educationally from a grade of 90 in cooking.

The main reason for this fact is that the Terman tests test different abilities from those tested by the major portion of group

* Reprinted from Mental Hygiene News, Dept. Mental Hygiene, State of New York, May, 1939, p. 1.

scales. The latter usually include tests for reading or thought content, arithmetical computation, and arithmetical reasoning. In other words, for the most part, the group tests test those abilities which are the results of instruction and training. It is for that very reason of educational placement that they were devised. The Terman scale—with some exceptions, of course—attempts to measure those capacities which are not so completely dependent upon formal academic training. For example, the Terman revision includes tests of memory span, of planning capacity, of associative ability, of visual and auditory imagery, of kinaesthetic sense, and of reasoning capacity in both concrete and abstract problems. These potential abilities are not included in the majority of the other scales. Therefore, despite the high positive correlation between the individual Terman examination and any other group examination, the results are not individually comparable.

In summarizing the above, let me emphasize the fact that from no other scale except the Terman individual examination—a new revisions of which is now available—can an I. Q. be derived, because from no other is an actual mental age determined. And secondly, that conclusions which hold true for thousands of persons cannot be assumed as true for each individual member of that group. Lastly, I do not wish to convey the impression that the Terman results are the final and irrevocable criterion of a child's intellectual equipment.

There are errors to be eliminated and defects inherent in the tests to be corrected. But, to date, they are the most accurate, the most reliable, and the most valid measure of general mental capacity which is available.

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Children's Dentistry,—The Department of Health of the City of New York has pioneered in providing dental service of a preventive nature for school children of families in the lower income brackets. This program is limited to the care of children's teeth, for it is recognized that preventive dentistry for children is the first step in the control of dental disease.

About 90,000 school children are now receiving dental care in 117 schools and 19 health centers in Greater New York, according to Dr. Harry Strusser, Chief of Dental Division, Department of Health of the City of New York.

This service represents a major accomplishment, and is a long distance from the day when relief of toothache was the chief reason for a child to visit a dentist. As part of its dental program, instruction in dental health is included in each school's curriculum. Instruction is also made available to mothers covering the pre-natal, infancy, and pre-school periods. The New York Journ. of Dentistry, May, 1939, p. 211.

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EDITORIAL

"Vincere Est Vivere"

Thus reads the motto enscrolled on the coat of arms awarded John Smith by Prince Sigismund as an honor and an award for deeds of prowess and valor on the field of battle. "To overcome is to live" is just as true today as it was three and one-half centuries ago. It is true in war and in peace, in industry, in education, and in public health.

The school year, 1938-1939 draws to its close. The program of school health for this year marches to its end. We mean *marches*, it does not merely drift, not if it is getting to any definite goal. As we have marched, what objectives in the program have we overtaken?

What of health education? Has information concerning personal and community health been acquired by school pupils and their parents? How much of this has proven worth while—has been translated into better health habits and activities and environment?

Has the physical condition of the school plant been improved? Are facilities for sanitation, for physical activities, for recreation, for providing nutritious foods better in actuality and in management?

Is the cafeteria a pleasant place, well lighted, well ventilated, attractive? Does its management appreciate and emphasize the hygienic value—mental and physical—of good food combinations, properly cooked, tastily served, and leisurely eaten? Is the "cafeteria period" a social hour, with time for rest and relaxation for both pupils and teachers, or is it a "gobble and git" turmoil?

Have communicable diseases among children of school age been lessened? Have we made provision so that these diseases will be lessened next year, and the years after? How nearly perfect is our record for vaccination against small pox? What percentage of school children are inoculated against diphtheria? Is this a larger percentage than last year? Has our community achieved the honor roll by having no deaths from diphtheria, or scarlet fever during the twelve months just closing?

The real purpose of making physical or health examinations is not so much to find deviations from normal as it is to bring about restoration to the normal. What progress has there been here? Is the percentage of correction of abnormalities higher this year than last? How does it compare with a five year period? What do you plan to do next year to improve your record?

And what about the physical education program? Is it a *program* of carefully planned series of activities having real gradation based on studies of pupil accomplishment? Are pupils sent to class grouped on the basis of skills and power, or are they

in the class merely because the members of the group have a vacant period at that particular day and hour? Is it a program for all, difficult enough to stimulate effort and interest, but not so vigorous as to be dangerous or exhausting? Or is it merely a series of inter-scholastic contests, largely controlled by the poolroom athletic council? Is the instructor in charge merely a coach, who has been put in charge of physical education so that he may have a full time job and thereby increase the state aid to the school district?

Are your records of physical examinations and of re-examinations sufficiently exact so that you can find out whether a defect found on re-examination appeared one year after the first examination or, shall we say, five years after the first? Such care would make it possible after a number of years to have some *scientific* evidence as to how often physical examinations should be made. At present we are guessing. The law in the State of New York requires an examination annually: an article in this issue by Wilson and Clancy advises four, two in the elementary school years and two in the secondary: The Report on the School Health Program based on the Regents Inquiry (New York) advocates three. Who is right? Nobody really *knows*.

Are the personnel engaged in school health activities trained for their jobs? What are they doing to make themselves better fitted? Do they attend medical and educational meetings regularly? Do they take—and *read*—professional journals and books? Do they attend summer school or take advanced university courses? In brief—are they competent and "on the job"?

Are these nurses, doctors, dentists, teachers, and administrators a *team*, or are they just specialists, each splashing in his own pond, creating a huge commotion, tossing much water about, but getting nowhere? "Watchman, what of the night?"

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ABSTRACTS

Trends in School Health Examinations,—Health examinations are now considered an essential part of all school health programs. Parents expect that such examinations will be made. Teachers are asking that they be informed of defects in seeing or hearing which may interfere with the academic accomplishments of their pupils, and conditions which may limit or modify their recreation programs. Despite this common acceptance of school health examinations, the procedures used and the end results attained are continually being scrutinized by educators, school health workers, health officials, parents, and others. As a result of this scrutiny and study, it is quite likely that future school health examinations will be as different from those of today as today's examinations are different from those of a decade or two ago.

Four trends or emphases in school health examinations will be discussed here. These trends are:

1. To emphasize the educational implications of the examination and the nurse's follow-up of examinations.
2. To encourage examinations by private physicians.
3. To favor less frequent but more thorough examinations.
4. To emphasize the need for day-by-day observations of pupils by parents and teachers as a supplement to periodic health examinations.

Educational Implications,—The educative value of health examinations is being discussed by educators and physicians. The educator is thinking of education as a group of planned experiences. In this light he regards the health examinations as a planned pupil experience from which it is expected the child will learn certain facts about health and about physicians. The physician thinks of the educative influence of the examination because he has learned that pupils' attitudes toward the entire medical profession and pupils' concepts of the value of health examinations may be greatly influenced by the attitude of the school physician, his method of making the examination, and his comments to pupil and parent.

Stimulating Parent Initiative,—Schools are tending to capitalize on the interest of the large numbers of parents of kindergarten and first-grade children who come to the school for the child's first physical examination, by examining all the children in the same family at the same time. The advantage of such a procedure is easily seen. The first part of the interview is given over to the establishment of rapport with the parent. Frequently only one child in the family has a condition for which further medical follow-up is needed. The parent has been made to feel that she is taking an active part in the discovery of such a defect. Playing such a role, she is more apt to take the initiative in securing medical care for the condition than if the school, through a notification slip, informed her of the defect some time following the child's examination.

The Private Physician,—There is a growing and desirable tendency for schools to encourage parents to have pupils examined by their private physician. Undoubtedly there have been varying motives for this step in different communities. One does it because it makes pupils and parents less dependent on the school for medical advice. Another community encourages examinations by private physicians so that the school physician will have more time for examining other children needing special attention. A neighboring school does it as a cooperative measure with the county medical society because of the realization that school health examinations are limited in scope and ordinarily cannot include some of the laboratory measures which the private physician can carry out in his office.

Frequency of Examinations,—It should be quite clear that at the present time we have no scientific data which will tell us whether school examinations should be given every month, every six months, every year, every two years, or every four years. In order to get a scientific answer to the question, records must be kept to indicate the *new* conditions which are found at each examination, separate from conditions which were known previously. We shall also have to consider the educational purpose of the examination and find an answer to the question, how often is a health examination desired as an educational experience? After accumulating these data, we shall have to consider the cost, to determine whether the anticipated gains are commensurate.

It is the belief of many that four routine school-sponsored examinations by a physician during the school life of a pupil—two in the elementary and two in the secondary period—are sufficient to discharge the school's responsibility. These four examinations—together with the day-by-day observations of pupils by parents and teachers, and arrangements for securing further examination and medical care when needed—should detect most abnormal conditions affecting growth, health, and school progress. They should also afford teachers the information necessary for understanding their pupils and adjusting school programs to their needs.

Day-by-Day Observations,—The limitations of health examinations in finding pupils in need of medical care were mentioned above. Because of these limitations, we find that considerable emphasis is now being placed on the day-by-day observation of pupils by parents and teachers, and careful procedures are being developed so that parents and teachers will know how to refer, for further examination, those pupils who show deviation from the normal. These things are done so that parents may be guided to sources of treatment.

As mentioned at the beginning of this article, school health programs are not static. They change with changes in education and in public health viewpoints. We cannot predict the form of future school health programs. But we feel safe in assuming that safeguarding and promoting the health of school children will continue for many years to challenge the cooperative efforts of school administrators, teachers, school nurses, physicians, dentists, public health officials, and others interested in health. By Charles C. Wilson, M.D., and Helen M. Clancy, R.N. Public Health Nursing, April, 1939, page 219. Abstracted by E. E. Kleinschmidt.

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School Health Policies,—This statement of school health policies is planned (1) to delineate the responsibilities of school health programs and (2) to relate the school health program to the health programs or health activities of other groups. In other words, it is an attempt to outline those things which schools should and should not do in the field of health.

The responsibilities of school health programs can be stated in many different ways. For purposes of discussion and simplification, the committee will consider all school responsibilities for pupil health under eight headings.

1. To provide a *Healthful Environment.* This includes attention to the arrangement of the school program and the social and emotional tone of the classroom as well as attention to school sanitation.

2. To have a *Planned Program for the Care of Accidents* occurring at school and for the cases of sudden sickness.

3. To have a *Planned Program for Assisting in the Community Program of Contagious Disease Control.*

4. To *Teach Pupils Habits and Attitudes* conducive to the maintenance of good health, and to *Facilitate the Accumulation of Scientific Knowledge* relating to the causes of disease, the way certain diseases are spread, and the known methods of preventing disease from the point of view of both individual and community health.

5. To *Encourage the Periodic Health Examinations* of pupils, to develop a plan whereby such examinations will be obtained, and to keep a cumulative record of the findings and recommendations.

6. To *Give Special Attention to Those in Need of Medical or Dental Care* through a follow-up program which will, where necessary, guide pupils and parents to sources of medical and dental treatment.

7. To *Provide Special Education Programs* adapted to the needs of handicapped pupils.

8. To *Provide Supervision and In-Service Training for Teachers* and to place specific responsibility in the hands of some person especially qualified in education and in school health work for coordinating all school health activities and for relating these to community health programs.

In conclusion, it may be repeated that as various groups interested in child health work together and discuss their objectives, and these problems, it will be found that improved techniques will be evolved, debatable issues will evaporate, and more effective and efficient programs will be developed.

Policies change with time. The committee is aware of this transient nature of policies, but believes that progress and understanding are dependent on clear-cut statements of viewpoints.

Through definite, specific statements of policy, it hopes to contribute to the progress of school health programs. **Suggested School Health Policies.** 35 pages. Report of Sub-Committee on School Health Policies, State Department of Education, Conn. Abstracted by E. E. Kleinschmidt, M.D., D.P.H.

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Is Your School Safe?—School buildings, school equipment, and school grounds should be most carefully checked over to make sure that everything is in the best possible repair for the school year; that no accident and health hazards to pupils and teachers remain. Here are a few important things to look into:

1. Is the water supply safe? Has it been tested? Is a plentiful supply of good, clean water available without danger of pollution in any way?

2. Is the school building properly heated and ventilated? Are all fire hazards removed? Do doors open outward? Can egress be had by fire escape or window if need be? What about defective boilers, poor oil or gas heating arrangements, inadequate ventilation, dangers of explosions due to careless handling or storage of paints, varnishes, and other inflammable materials? Does your school have fire hazards due to spontaneous combustion of accumulations of oiled rags, debris, etc.?

3. Are the playgrounds and their equipment in as safe a condition as they can be made? Is there sufficient play space to avoid congestion? Is it clean and well drained? Has the play apparatus been checked over? Have all necessary repairs been made?

4. Have all vehicles used to transport pupils been placed in best possible repair? Are they clean and safe? Have all routes, drivers, driving regulations, and the like been restudied in the light of last year's experiences to make sure that this part of the school's service is as safe as it can be? What about railroad crossings? Have safeguards been worked out governing approaching or passing cars while loading or discharging pupils?

5. Has all electrical wiring been done or checked over by a qualified electrician? What about unnecessary or worn extension cords, defective switches, improvised fuses? Has basic instruction been given pupils concerning dangers from electricity when not properly used or when wires are broken or exposed?

Who has the responsibility for checking up on these and other matters relating to health and safety? Who is responsible for getting necessary repairs properly and promptly made? These matters of health and safety are so important that they should be brought to the attention of the proper authorities without delay, and necessary actions taken to prevent every possible danger to boys and girls in every community. Walter H. Gaumnitz, School Life, October, 1938, page 27. Abstracted by Earl E. Kleinschmidt, M.D.

Are We Modern,—In Rhode Island, most densely populated of all the 48 States, 46 one-room schools are operating during the school year just about as they operated 100 years ago. Inside, the surroundings look much as they did a century ago, with heat provided by an old-fashioned coal or wood stove and artificial light provided, when necessary, by kerosene lamps. Most of the one-room schools left today were built a half century or more ago. One recently was destroyed in a fire after serving its community in Exeter continuously for 128 years. It is being rebuilt. From Journal of Education, appearing in School Management, April, 1939, p. 183.

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REVIEWS

The New Archery; Hobby, Sport, and Craft.

Paul H. Gordon. D. Appleton-Century Co., New York, 1939. Pp. 423. $3.50.

This is a comprehensive text on a skill and sport which is rapidly increasing in popularity. It has become an important part of the program in physical education for women in most colleges and in many high schools. The activity program for boys and men should be broadened to include this healthful recreation, one of the great values of which is that it can be used in nearly all places and seasons, and for as late in life as any vigorous physical activity is permissible.

After sketching the history of the sport, it goes into great detail as to techniques and management, of specifications and procedures in making "tackle",—bows, arrows, and targets—and has a section on leadership in camps, especially as regards teaching archery and developing it as a sport and a recreation.

This is a most interesting and instructive book and well worth having by any one interested in teaching or practicing this sport. Charles H. Keene, M.D.

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Administration and Supervision of School Health Service. University of the State of New York Bulletin. Health Education Series. Bulletin No. 1. December, 1938. Pages 136.

This excellent bulletin forms a very worthwhile manual of instruction for school administrators, physicians and nurses, serving to aid them in the provision of a more satisfactory health service and continuous health supervision for all pupils. Inasmuch as a school health program is provided for by the State of New York through its Medical Inspection Law enacted in 1913 this definite, well-outlined manual of information and instruction is based primarily on the school health system as found in this state and is designed to meet its needs.

An analysis of its contents reveals that Chapter I is devoted to principles underlying school health service and supervision. Recognition is given of the fact that sound administration and super-

vision must be based on existing needs and that the primary functions of school health service and supervision are:

"1. To maintain a healthful school environment and conditions which are conducive toward the realization of all educational objectives.

2. To promote healthful conditions of pupils and teachers so that education can go on most effectively. This function includes the examinations to determine the health status of the individual and the follow-up to secure needed corrections and educational adjustments.

3. To provide situations in which the child develops habits of healthful living. This function involves the arrangement of situations that the pupils' experiences will produce such desirable results as:

(a). Responsibility for the intelligent care of his health

(b). An appreciation of the value of qualified health service to the individual, the group, and the community.

(c). The value of the use of public health procedures, such as vaccination, in the protection of life and health

(d). Knowledge regarding the wise selection and use of professional health services."

A statement is made of policies emphasizing the educational function of the service rendered and dealing with such aspects as approved and adequate personnel and facilities, records, reports made by the schools to the Department of Health and Physical Education, the continuity of the health service given, health examinations, procedures regarding medical recommendations, notification of parents regarding defects, the nature and extent of the school's responsibility for treatment, health inspections by teachers, nurses etc., public relations, use of opportunities for health education through health service, guidance of parents, children, and teachers, emergencies, health aspects of the school plant, and hygiene of instruction.

Chapter II discusses:

1. Emergencies, giving a suggested list of instructions for first aid

2. Health and safety aspects of the school plant

3. Hygiene of instruction as related to scheduling of classes and activities, rest periods, home work, texts and reference materials, noon recess, health of the school personnel, teacher load, and length of the school day.

4. Consultative and advisory health service.

School health examinations, tests, and inspections receive the major share of attention in Chapter III. Following a statement of the purpose and objectives of these examinations along with the facilities and equipment necessary, the following types of examinations and tests are elaborated upon:

1. Annual health examinations including daily health inspections
2. Subsequent health examinations
   (a). Referred cases
   (b). Exclusions and readmissions
   (c). Emergencies
   (d). Communicable disease control
3. Special health examinations
   (a). Employment certificates
   (b). Vacation work permits
   (c). Exemption certificates
   (d). Athletics
   (e). Preschool (special group)
   (f). Physically handicapped children

The information in Chapter IV relates to the follow-up for treatment of defects and special adjustments necessary to meet individual and group needs.

Since the satisfactory functioning of a school health service is largely dependent on the service of certain personnel, the responsibilities of the trustees and boards of education, the school administrators, health specialists, and general school personnel are given consideration in Chapter V.

Chapter VI is especially valuable for its illustrations and discussion of the large number of record and report forms used in relation to the school health service.

Legal provisions relating the school health service and supervision in New York State are contained in Appendix A, while at the close of the bulletin is found a bibliography and directory of publishers.

This manual has a real place in the library of anyone professionally interested in the field of school health. Earl E. Kleinschmidt, M.D.

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MEETINGS

The Health Section of the World Federation of Education Associations, through its chairman, Dr. C. E. Turner, cordially invites you to participate in the meetings of the Eighth Biennial Conference to be held in Rio de Janiero, Brazil, August 6-11, 1939.

The American School Health Association and the American Public Health Association, October 16-20, Pittsburgh, Penn. The headquarters of the American School Health Association will be at the Hotel Roosevelt. Members should make early reservations of rooms at this hotel.

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School health position, by mature young woman, now employed in public schools.

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